AUTHORIZATION AND CONSENT FOR USE OR DISCLOSURE OF PHOTOGRAPHY

All portions will be completed – front and back.

I, _____ (Print Name)

Authorize the following Public Health programs:

- ❑ Community Health Services
- ❑ Medical Examiner
- ❑ Jail
- ❑ Other (specify): _____
- ❑ Emergency Medical Services
- ❑ Administrative Services
- ❑ Specialty Clinics

To take and reproduce:

- ❑ Photographs of my face
- ❑ Photographs of my body
- ❑ Photographs of my internal organs
- ❑ Video of my face
- ❑ Video of my body
- ❑ Video of my internal organs

For the following purpose(s):

- ❑ Education
- ❑ Publication
- ❑ Other purposes:

_____

(if for Public Relations, see also next page)

Person / Organization to receive the information: _____

I further authorize that such photographs may, at the discretion of the Public Health program, be made a part of the health record and may be made available for disclosure, as with my other health records, upon receipt of a valid authorization.

Unless revoked or as otherwise provided herein, this authorization expires _____ **(insert either applicable date or event)**. If this authorization requests that health information be used by or disclosed to the client's employer or a financial institution, this authorization will expire 90 days from the date signed.

Revocation: I understand that I may revoke this authorization by submitting the revocation in writing to the Public Health Privacy Office, at any time except to the extent that action has already been taken based on the original authorization.

I understand that I have the following rights: a) To inspect or to receive a copy of my protected health information, b) To receive a copy of this signed authorization and c) To refuse to sign this authorization.

I also understand that Public Health will not condition treatment or payment based on receipt of this signed authorization.

Continued on next page

This is a permanent part of the health record

AUTHORIZATION & CONSENT TO USE OR DISCLOSE PHOTOGRAPHY Public Health Seattle & King County HEALTHY PEOPLE. HEALTHY COMMUNITIES.	Patient Name: HR #: D.O.B.:

REDISCLOSURE PROHIBITED FOR CERTAIN INFORMATION: Once disclosed, the recipient of your information may not be required to maintain the confidentiality of your health care information. However, if you authorize the disclosure of health information containing sexually transmitted disease information, state law prohibits redisclosure (Ch. 70.24 RCW.) If you authorize disclosure of information containing drug or alcohol treatment information, redisclosure is prohibited by federal law (42 CFR Part 2).

The following will be filled out by Public Health prior to the patient signing this form:

1. This authorization also includes information related to the following conditions:

   - ☐ Not applicable
   - ☐ Diagnosed Sexually transmitted disease
   - ☐ Positive HIV/AIDS testing
   - ☐ HIV/AIDS treatment
   - ☐ Mental Health
   - ☐ Drug/Alcohol Abuse

2. For all public relations activities:

   A. Specifics of the public relations program are described below, including an explanation of client selection criteria:

   _____

   _____

   _____

   _____

   B. A Public Health workforce member will identify below whether or not Public Health will receive direct or indirect remuneration from a third party for these services.

   - ☐ Remuneration will be received by Public Health
   - ☐ Remuneration *will not* be received by Public Health

APPROVED

APR 05 2010

UW Human Subjects
Review Committee

This is a permanent part of the health record

_____ _____

SIGNATURE (PATIENT OR PERSON AUTHORIZED TO GIVE AUTHORIZATION) DATE

_____

IF SIGNED BY PERSON OTHER THAN PATIENT, PROVIDE REASON, RELATIONSHIP TO PATIENT, DESCRIPTION OF THEIR AUTHORITY